



California Society of Addiction Medicine

A specialty society of physicians founded in 1973.
Since 1989, a State Chapter of the American Society of Addiction Medicine

Recommendations for Improvements to Proposition 36 (Substance Abuse Crime Prevention Act of 2000)

Presented by

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Little Hoover Commission
23 August 2007
Sacramento, CA

California Society of Addiction Medicine:

CSAM is a chapter of the American Society of Addiction Medicine. Its members are over 400 physicians practicing in the state of California. The Society's mission is to provide physician leadership for evidence-based medicine, to provide education in addiction treatments, and to advocate for patients suffering addictive disorders.

CSAM was a public proponent of Proposition 36 (The Substance Abuse and Crime Prevention Act, or SACPA) when the voters passed it in 2000. It mandated diversion of non-violent drug offenders to treatment rather than prison. CSAM supported Prop 36 because it dramatically expanded Californians' access to addiction treatment and doubled the state funding allocated to treatment services. CSAM continues to support the program because it provides access to treatment for over 36,000 people a year, half of whom had never accessed treatment before.

Unlike treatment, incarceration is a growth industry in America. In 1980 we had one million persons in prison, twenty years later we had more than doubled that, largely on the basis of drug-related sentencing. In 2000, California led the nation in incarceration for drug-related charges. Minorities in particular suffer disproportionately high rates of incarceration and criminal records that follow for life.

There are no penicillin-like magic bullets for addictions, but the evidence-based treatments in the medical literature show moderate positive outcomes over time.. Incarceration is a blunt tool, used relentlessly in the criminal justice sector, and it has failed with addicts. Treatment fails too, but clinicians have significantly more kinds of less punishing interventions (medications, residential care, group therapy, and so on), and at far less expense to the tax base and with less cost to individuals' future employability.

Finally, it is good to remember that a year in prison costs more than a year at Stanford University, that Prop 36 allowed California to avoid building two new prisons, that UCLA has demonstrated that every \$1 of treatment saves \$2.50 in state costs for enrollees and \$4 for treatment completers. UCLA found that 78% of people who completed treatment reported being drug-free one year after their sentence and 59% had found jobs.

Addictions & the Public Health Model:

Volumes of scientific research support that addictions are chronic relapsing disorders, similar to hypertension, diabetes, and heart disease. All show episodic noncompliance with medications, waxing and waning symptoms; and, all require lifestyle changes for proper management. Although there are no cures *per se*, there are effective treatments for all. As in all chronic medical care,

best treatment practices are a combination of medical and behavioral interventions.

It is now established that genetic vulnerability explains 50-60% of the risk of developing alcoholism; and, similar studies support significant genetic risk factors for stimulant and opiate abuse as well. Among environmental factors, traumas, both domestic and combat, increase risk of addiction. In youth, the influence of peer groups reliably exceeds that of parents.

California is in the midst of a methamphetamine epidemic that is moving eastward across the states. Prop 36 clients reflect this pattern, 53% have been convicted of a methamphetamine offense and are treated for addiction to this inexpensive drug of choice.

Treatment offers no magic bullets, but new technologies have hastened medication development. There are now three medications approved as effective for reducing alcohol relapse, three for treatment of heroin or opiate addiction, but none to date for the treatment of stimulant addiction (however, several very promising drugs such as modafinil are in the NIDA human research pipeline).

Psychosocial interventions remain the bulwarks of addiction treatment; and, they range from self-help groups such as AA, to clinic groups, to residential care. Recent work has asked about effective "doses" of psychosocial treatments. Research finds that 90 days of participation seems to be a threshold dose in many cases. For particularly complex patients, such as established recidivists or dual-diagnosis patients, effective stays in treatment need to be much longer.

CSAM believes that Prop 36 has made a very positive difference in treatment availability in California, but that systems anomalies can still be improved. We support interventions that have research support and a strong evidence-base.

CSAM Recommended Improvements:

1. Medication Assisted Treatments

- ✓ Access to Methadone Maintenance
- ✓ Medication for Dual Diagnosis disorders
- ✓ Anti-relapse medications

2. Psychosocial Treatments

- ✓ Patient Placement Criteria (ASAM PPC-2)
- ✓ Increased access to residential care

3. Assertive Case Management

- ✓ Drug Courts for criminal recidivists
- ✓ Outreach teams for dropouts
- ✓ Random, routine toxicology testing
- ✓ Payee management of welfare benefits

4. Outcomes Evaluation Research

- ✓ UCLA continuation support
- ✓ Development of core data set

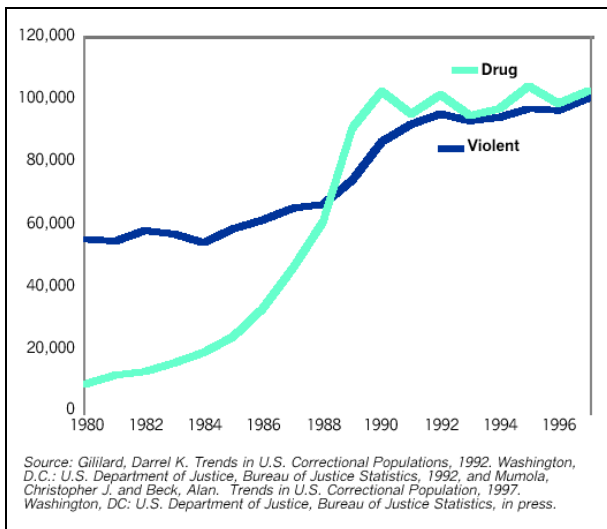
5. Improved Funding Base

- ✓ Improved funding support
- ✓ Pre-Incarceration focus

War on Drugs 1980-99:

Why did the public overwhelmingly support Prop 36 (61% vs. 39%)? We believe it is because Californians had grown weary of a *War on Drugs* that had, in the span of two decades, reversed Richard Nixon's original funding formula of 67% for treatment and 33% for interdiction. By 1989 our country was incarcerating more individuals for nonviolent drug charges than for violent crimes. In 1996 the general incarceration rate in the US was 44.6 per 100,000. In California it was 114.6 per 100,000 (or, 2.5 times the national average).

USA Drug vs. Violent Crime Incarcerations



In 1996, California's rate of incarceration for drug offenses was the highest in the nation (134.09/100,000), followed distantly by Louisiana, New Jersey, and New York (80.79/100,000). And in 1999, the general incarceration rate was 132.0 per 100,000.

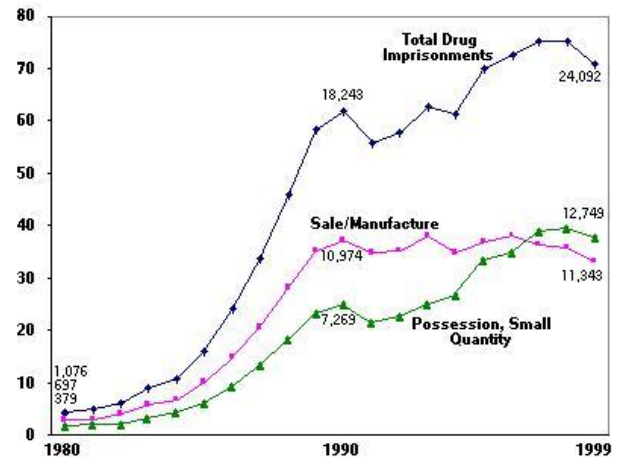
USA Highest Drug Offense Incarcerations

| State | 1986 Rate* | 1996 Rate* | %Change |
|----------------|------------|------------|---------|
| California | 36.47 | 134.09 | 267.63 |
| Louisiana | 3.56 | 106.55 | 2890.84 |
| New Jersey | 11.04 | 85.26 | 272.63 |
| New York | 25.03 | 80.79 | 222.74 |
| North Carolina | 24.46 | 76.69 | 213.57 |
| Illinois | 11.14 | 73.25 | 557.33 |
| South Carolina | 29.35 | 70.98 | 141.87 |
| Maryland | 22.11 | 68.30 | 208.93 |
| Mississippi | 19.39 | 68.30 | 252.20 |
| Georgia | 2.96 | 64.46 | 2078.82 |

* rate per 100,000

Source: National Corrections Reporting Program, 1986, 1996 data

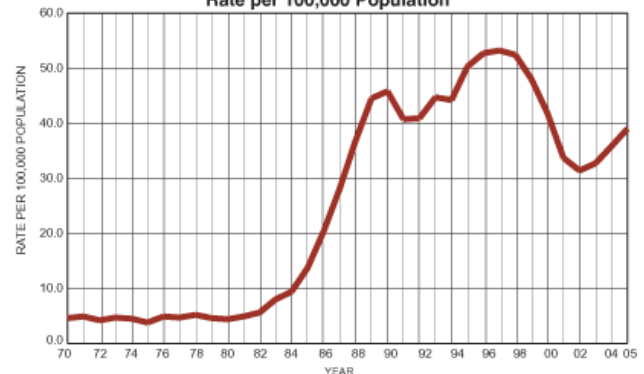
Figure 1: California Drug Imprisonments, 1980-99



California's dramatic rise in imprisonment began in 1985, coincident with the introduction of smokeable "crack" cocaine to our communities.

Between 1980 and 1999, both the US and California ramped up a "War on Drugs" that saw increasing numbers of imprisonments for drug related charges. In those two decades (1980-1998) California arrest rates for drug offenses increased by 46.5%. Indeed, by 1999, two lines had crossed—the majority (52.9%) of California's new drug imprisonments were now for possession rather than sale or manufacture.

California INCARCERATION RATES FOR DRUG-RELATED CRIMES, 1970-2005 Rate per 100,000 Population



Proposition 36 has successfully reduced drug incarceration rates and modestly reduced the overpopulation of our prisons. And, it has afforded treatment to thousands of Californians, the majority finding themselves in treatment for the first time in their lives. Prop 36 has given the public health approach to non-violent drug possession its first serious chance in 25 years.

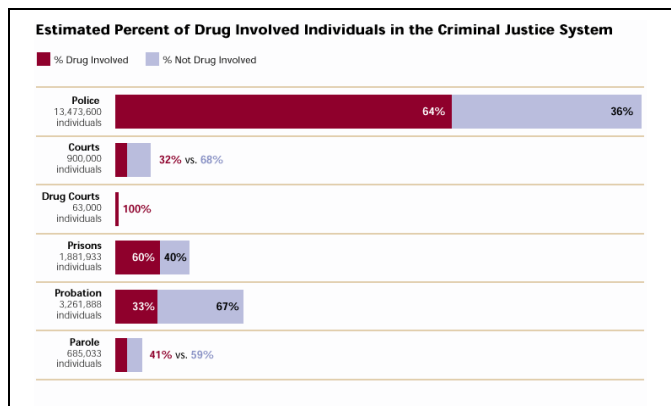
Drug Courts:

In many ways the criminal justice system has become the *de facto* treatment system of last resort for people who fall through the cracks of California's social services systems.

In 1999, by their own data, Drug Courts in California handled only about 3% of at-risk arrestees. They had inconsistent treatment standards; and, individual judges frequently prohibited the gold-standard Opiate Agonist Treatments (methadone, buprenorphine, or LAAM) for heroin addiction. In face of great need, they were, like community-based treatment programs, significantly underfunded and understaffed.

In our opinion, Drug Courts should specialize in the highly recidivistic clients that require their additional supervisory and monitoring capabilities.

- **Drug Courts should handle the highly recidivistic 1.6% of clients in Prop 36.** This group accounts for ten times the expense of all others and they are easily defined by 5 convictions within a prior 30 month period.



Source: Center for Substance Abuse Treatment (SAMHSA/CSAT) 1997, Federal Bureau of Prisons; data prepared by Physician Leadership on National Drug Policy National Project Office

Criminal justice lobbyists argue that SB 1137 will simply modify Prop 36 to follow the drug court model. However, returning pre-2000 incarceration options to regular judges will in no way make their courts into the more complex and expensive drug courts. Drug Courts can be more effective than standard courts, because they have many other sanctions (community service, court appearances, urine toxicology testing) and structures (liaisons with treatment facilities, social work assessments, probation visits, and frequent court appearances). This makes them very unlike regular courts and very significantly more expensive. In no way will simply returning broad incarceration powers to sitting judges turn their courts into drug courts, as asserted by some enthusiasts of this blunt instrument.

Senate Bill 1137:

Despite the overwhelming evidence that Prop 36 saves hundreds of millions of dollars and improves thousands of lives, we physicians find ourselves again disputing police, prosecutors, and corrections officers who assisted Senator Ducheny in drafting SB 803 to “improve” Prop 36. This bill later passed as SB 1137. It has been challenged in court by the original SACPA proponents (Drug Policy Alliance) with support from CSAM and the California Medical Association and the California Psychiatric Association.

As physicians we do not interpret constitutional law, but we must note that the State Legislature's own lawyers have written¹ that elements of the bill would violate the intents and purposes of the voter initiative. **We do not feel that criminal justice officers should practice medicine by trying to define incarceration as a component of treatment.** It is not. Jail sanctions are bad medicine, bad policy, and most probably an unconstitutional repudiation of drug-war-weary California voters who demanded a shift to a public health model.

Flash Incarceration:

CSAM's position is to support Drug Courts, but to oppose “flash incarceration” on the basis of (a) its manifest failure in the prior 30 years in the War on Drugs, (b) its scant research evidence base, and (c) its patent inability to bring standard courts into “the drug court model.” If the latter assertion were so, then *all* California courts were drug courts before 2000. **Flash incarceration is not an improvement, it is a regression to the failures of the past.**

Opponents of Prop 36 criticize the treatment refusal and no show rates. But, it is important not to confuse criminal justice apples with addiction treatment oranges. Treatment refusals and no-shows (~30%) can in no way be blamed on treatment. Those are pre-treatment individuals who remain criminal justice responsibilities.

Modern medicine is evidence-based, and we find no significant evidence to support “flash incarceration” as a uniquely robust treatment tool (although it has a kind of common sense attractiveness). Its claims rest largely on anecdotal reports. We all know by now that addiction as a process must be much more than a lack of attentiveness to real-life consequences.

We join the *California Medical Association* in conceptualizing addiction as a medical and public health problem and not as a moral or criminal one. We are concerned that the courts want to use flash incarceration as a kind of blunt instrument for everything from treatment refusal, to bad attitude, to relapse.

¹ California Legislative Counsel, Legal Opinion Letter in response to Hon. Karen Bass, State Capitol, April 18, 2005.

The California State Prison System:

Today the state's prisons house more than 172,000 inmates in facilities designed for about half that. At the present time, California has the highest drug-related incarceration rate and the highest parole/probation violation-related return to prison rate in the nation (70%), both contributing to massive overcrowding.

A historic prison agreement (AB 900) signed on April 25, 2007 adds 53,000 new beds, the most in a generation, to California's prisons and jails. \$6.1 billion dollars will pay for 40,000 new beds in state prisons; and, \$1.2 billion will pay for 13,000 new beds in local county jails. 16,000 new beds will be added to the major facilities.

The Governor has directed his Administration to establish strike teams within CDCR's management to speed up construction and overhaul rehabilitation, substance abuse, education and job training programs. Kathy Jett, former Director of the Department of Alcohol and Drugs, will oversee the rescue of the rehabilitation components of in-custody and parole treatment programs.

Rehabilitation services—like substance abuse treatment, mental health services and vocational education—will accompany all new bed construction. 4,000 beds (2,000 in prison and 2,000 aftercare beds) will be devoted to drug treatment. Of \$7.3 billion dollars, about \$50 million is earmarked for rehabilitation services.

In-Custody Treatment:

Arrestees for all offenses show high rates of illicit drug use prior to imprisonment. This has led to vast, expensive, and failing "in-custody" treatment programs that are largely beyond the scope of this limited discussion.

**Percent of California Arrestees
Positive for Drugs (1998)**

| | Sex | Los Angeles | San Diego | San Jose |
|-----------------|---------|-------------|-----------|----------|
| Any Drug | Males | 64.4% | 68.6% | 48.2% |
| | Females | 71.0 | 63.9 | 41.5 |
| Cocaine | Males | 42.7 | 19.1 | 8.0 |
| | Females | 44.7 | 20.4 | 9.5 |
| Marijuana | Males | 27.3 | 36.4 | 24.8 |
| | Females | 21.8 | 26.7 | 13.6 |
| Opiates | Males | 5.6 | 9.3 | 4.4 |
| | Females | 8.8 | 6.7 | 4.8 |
| Methamphetamine | Males | 8.0 | 33.4 | 19.7 |
| | Females | 11.8 | 33.3 | 21.1 |
| PCP | Males | 2.3 | 0.9 | 2.1 |
| | Females | 1.3 | 0.8 | 2.7 |
| Multiple Drugs | Males | 21.4 | 27.8 | 11.9 |
| | Females | 22.9 | 26.3 | 12.2 |

However, many of us have read the devastating report² from the Inspector General on the dismal state of so-called "in-custody treatment," a billion dollar boondoggle.

A 2006 review by UC Irvine's California Policy Research Center also found a dismal state of affairs.

Fewer California inmates participate in rehabilitation programs than those in comparable states, although its inmates have higher-than-usual needs for alcohol and drug-abuse programs. Forty-two percent of California inmates are estimated to have a "high need" for alcohol treatment (43% nationally), but only 7.5% of those will participate in some alcohol treatment in prison (18% nationally). The need is even greater for drugs. Fifty-six percent of all California inmates have a "high need" for drug treatment (49% nationally), but only 9% of those will participate in drug treatment in prison (19% nationally).³

The 2007 Inspector General's Report reminds us that **the rhetoric of treatment is not the same as real treatment**. The report found that the California Department of Corrections and Rehabilitation has provided such poor drug treatment services behind bars that the services had no positive impact whatsoever, despite a \$1-billion cost.

Addiction treatment after discharge, by contrast, was been shown to be beneficial

What does this have to do with Prop 36? The governor's office has indicated his plan to move the funding base of Prop 36 gradually from an independent trust fund to the Office of Offender Treatment Programs (OTP). CSAM is opposed to this shift. It not-so-subtly shifts from the voters' public health model back to an incarceration model. And, the state incarceration system is already handsomely funded, especially after AB 900.

- CSAM opposes placing Prop 36 under OTP.
- CSAM recommends that Prop 36 resources be reserved for pre-incarceration treatments.
- Prison inmates and released parolees should be treated under the oversight and separate funding base of the Department of Corrections and Rehabilitation.

As doctors specializing in substance abuse problems, we recommend that treatment be provided within the community whenever possible. Community-based treatment is not only effective at reducing drug abuse behavior but also costs far less than prison.

² Matthew Cate (IG), Special Review into In-prison Substance Abuse Programs Managed by the California Department of Corrections and Rehabilitation, Feb 2007.

<http://www.oig.ca.gov/reports/pdf/SubstanceAbusePrograms.pdf>

³ *Understanding California Corrections* by Joan Petersilia, University of California Irvine, and published by the California Policy Research Center. The full report is available at <http://ucicorrections.seweb.uci.edu/> or <http://www.ucop.edu/cprc/#>. May 2006

The Science of Addiction Treatment:

Addiction is a brain disease. Although addicted persons have many features in common, there is no evidence to support an underlying “addictive personality.” And, there is no evidence to suppose that failures of willpower or ego strength have much to do with addiction risks. But, inheritance of genetic vulnerabilities is an increasingly understood risk factor.

Treatment works, but it does not cure. Addiction is not like a gallstone subject to excision. It is a chronic relapsing disorder that requires early intervention and chronic care. Excellent sustained sobriety outcome rates at one year (for any addiction including cigarettes) are in the 20-30% range. People with something left to lose will always show statistically better outcomes. And, some highly disadvantaged cohorts will do worse. They will repetitively use jail or hospital time for a respite from street life and for “three hot’s and a cot.”

Relapse is not best conceptualized as a moral failure of the patient; it is better understood as a failure of the current treatment structures to support abstinence against drug use. Following this logic, relapses lead not to punishment or banishment, but to a more intensified treatment program and greater demands, up to highly structured residential care. As in the rest of medicine, intensification of care is a basic principle in the management of malignant disorders.

Methamphetamine & Cocaine:

The majority of Prop 36 patients choose methamphetamine over all else. It is the one illicit drug selected in equal proportions by women, probably because of its energy-producing and appetite-reducing features.

Methamphetamine produces long-term brain damage to dopamine neurons. It has long been known that excess dopamine produces both a pleasurable high and, in higher doses, paranoia. What is less well-known is that chronic use can produce cognitive deficits and permanent paranoia and auditory hallucinations or major depressions (the “burnt-out speed freak”). Both the chronic psychosis and the chronic depressed state improve in response to modern psychotropic medications.

Having said that, the core treatment for stimulant addiction remains psychosocial in nature through group treatments and cognitive-behavioral methods. Proven treatments include Cognitive-Behavioral Therapy (CBT), Contingency Management (CM), and the Matrix Model, an intensive 4-month, manualized, and highly structured treatment developed at UCLA by Richard Rawson, Ph.D..

CSAM believes that stimulant addictions often require medical/psychiatric care for optimal management. To date, there are no anti-craving or relapse prevention medications for stimulant abuse, although NIDA has sponsored research for hundreds of compounds, and

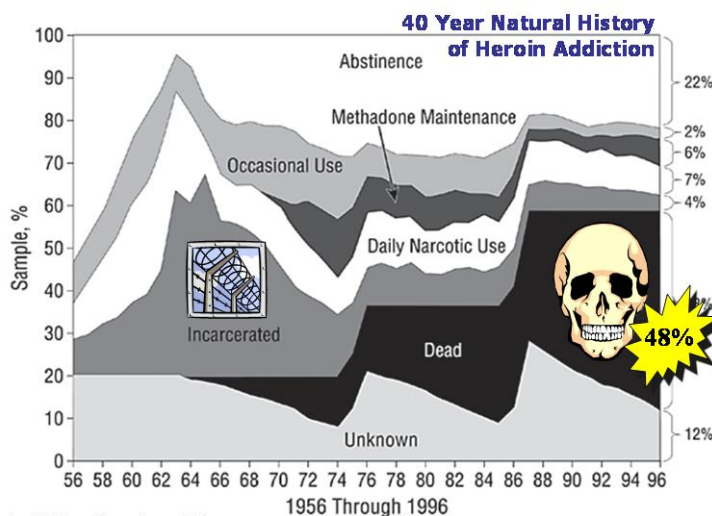
several promising medications (including Modafinil) are undergoing early human trials.

But, existing antipsychotic and antidepressant medications greatly improve stability and social functioning of these individuals. **Access to medications for this patient group increases the level of public safety**, but is difficult to find in community programs.

Heroin & Prescription Opiate Addiction:

The opiate addictions of choice in California are IV heroin and OxyContin (a form of oxycodone). Although the concept of opiate “detox” followed by drug-free recovery is ideologically appealing to all, it has failed the empirical test of time in literally hundreds of research studies. Quite frankly, most heroin detoxes fail (about 95%+) with a fairly prompt relapse. Since its development in 1965, methadone maintenance treatment has emerged as the gold-standard for effectiveness.

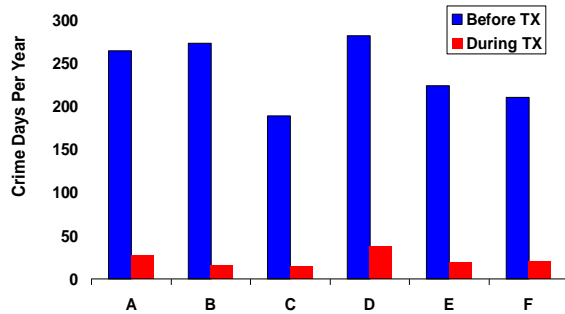
In Prop 36, approximately 10% of arrestees are heroin addicts, but only 10% of that cohort have access to life-saving opiate agonist treatment (methadone or buprenorphine). A ground breaking prospective study out



of UCLA followed Los Angeles heroin addicts after initial arrest for the next 33 years. They found that over 48% had died in the interim, and that relatively few had ever accessed methadone maintenance.

Methadone maintenance has been unequivocally shown to reduce jail time, heroin use, injection needle use, unsafe sex, HIV infection, and Hepatitis C infection. It demonstrably increases employment, medical health, and family stability. Methadone is highly regulated and can only be prescribed via specially licensed clinics. Buprenorphine, a partial opiate agonist, is a new medication that is an alternate form of agonist maintenance; and, it can be prescribed from specially licensed physician offices and is one answer for California’s rural counties without methadone programs.

Crime among 491 patients before and during MMT at 6 programs



Adapted from Ball & Ross - The Effectiveness of Methadone Maintenance Treatment, 1991

Nonetheless, opiate agonist treatments such as methadone maintenance are guaranteed to provoke strong ideologically-driven disputes. Most troubling, however, is the refusal of some judges (including some in drug courts) to permit methadone or buprenorphine maintenance. They insist on “detox” and thereby virtually guarantee relapse in a formerly stable patient. This is bad medicine, as practiced in some courtrooms. One reason is that there are still no national guidelines for Drug Courts, let alone regular courts, about the value of opiate agonist treatments.

The Alcoholisms:

We will soon be speaking of the *alcoholisms*. Why use the plural? Because alcoholism, like so many seemingly unitary diseases in the past (such as leukemia), is better conceptualized now as a group of final, common-pathway disorders with diverse genetic drivers, different biochemical anomalies and different responses to interventions. We now know that fully 50-60% of the risk of developing alcoholism is genetic inheritance, and there is certainly going to emerge a family of alcoholism disorders with genetic differences. The national *Collaborative Studies on Genetics of Alcoholism* (COGA) has identified many gene loci implicated not only in alcohol consumption, but in related phenomena such as impulsivity, risk-taking, and sensation seeking.



In Prop 36, as in all addiction treatment, alcohol use is ubiquitous. If it is not the drug of first choice, it is quite often the “downer” chosen in an “upper-downer” syndrome. Stimulant users often develop secondary alcohol addictions in their use of it to modulate the “jaggies” and to sleep.

There are three medications (disulfiram, naltrexone, and acamprosate) that reduce relapse rates in alcoholics. And, several more promising medications are in the research pipeline.

Individualized Anti-addiction Drugs:

Blood genotyping will soon lead to better medication choices. The goal is to identify one or more subtypes that respond to one or more medications. For example, patients who respond to naltrexone (an opiate blocker) for alcohol relapse prevention appear to have a genetic variant in the *mu* opiate receptor.

Biochemical and genetic progress is around the corner. But the genetics of the alcoholisms will necessarily force clearer thinking about public policy, lest we discover that our children are uninsurable due to genetic profiling of potential future risks.

Does "Recovery" Work?

What about recovery, the psychological side of the equation? Recovery is not really about willpower, to be sure, and it is also about more than neurochemistry. Recovery remains in great measure a psychological process of coming to terms with one's weakness, defect, or disease. It takes time and outside help; but, multiple slips or relapses most often precede stable recovery.

Most people cannot recover on their own; they have typically tried for years to “control” themselves and failed. Recovery starts when one person asks another for help. In this respect, this is an entirely human process, although we can dress it up in various fancier kinds of language, from Alcoholics Anonymous to sociology to psychiatry.

A career in addiction does a lot of damage to one's family and social nexus. Recovery brings with it the inescapable confrontation with the damage one has done to others. In this regard, it shifts the work away from mere chemical reward to entirely more complex questions, such as what it takes to gain personal redemption and forgiveness from those who have been harmed. It is why, perhaps, only the first step of AA's Twelve Steps even mentions alcohol. The rest are concerned with questions of personal integrity, making amends and eventually helping others less fortunate along the way.

Recovery is not as simple as the restitution of abstinence (an abnormal condition for most Americans) or a medical blockade of craving. The mystery of recovery is that it necessarily faces one with questions of how one is to live a life of integrity.

Recovery takes hard work; and, yes, it works.

The Most Difficult Cases:

What would real improvements look like? Let us look at the hardest cases—they cost the public the most and produce the worst results.

Treatment Refusers & No-Shows: Both groups should be considered as having *declined* Prop 36. They should remain liable to police pickup, probation violation, and jail as appropriate to the circumstances. They have never entered the treatment domain. At present, they are most often not picked up for probation violation unless/until they re-offend. A no-show to a treatment program who does not respond to outreach should be considered a *resignation* from Prop 36.

Dropouts: Courts and clinicians alike have been naturally reluctant to flunk people out of Prop 36 and have offered multiple re-entries under the same initial charge. This good heartedness has led to a perception among some of a Prop 36 “free pass.” Dropouts should be promptly scored by courts and clinicians as terminated Prop 36 episodes and treatment failures, respectively.

Relapsers: Appropriate intervention/treatment for this subgroup is actually the *only intractable dispute* between criminal justice and treatment. Flash incarceration is not a cure for relapses. A good one-year sobriety rate is around 30%, so it is clear that the majority of Prop 36 clients will relapse one or more times in the first year; and, this is part of the natural history of addiction. This is why an array of structured services is needed. A rule of thumb is that relapses require treatment intensification, up to, and sometimes including, residential recovery houses. One size does not fit all; and, more utilization of structured patient placement criteria will be helpful. The American Society of Addiction Medicine’s *Patient Placement Criteria* (PPC-2) warrants wider use.

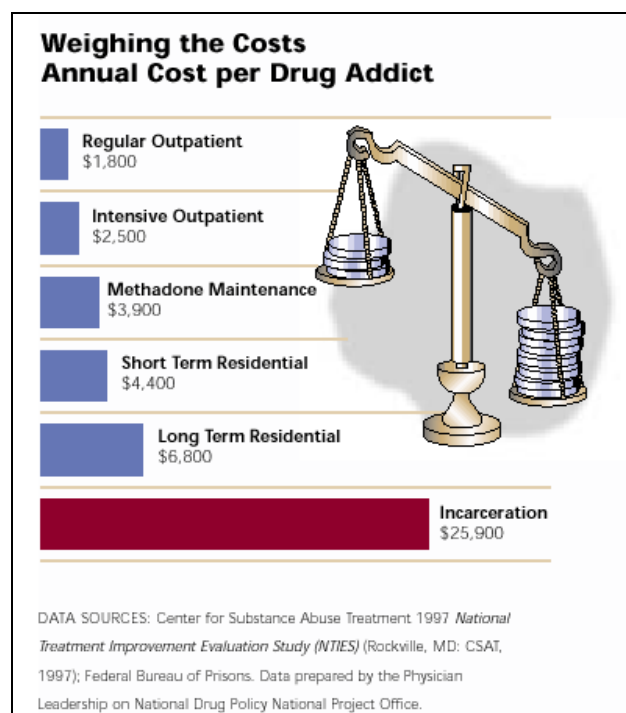
Criminal Recidivists: UCLA identified 1.6% as using up 10 times the resources of average defendants. They are defined by ≥ 5 convictions in the prior 30 months. They should be identified early after the index re-arrest and referred directly to Drug Courts for intensive supervision and judicial sanctions. Drug Courts, not standard courts, should be the intensive care units for these refractory individuals.

Heroin Addicts: Ten percent of Prop 36 clients are heroin addicts, but, less than 10% of them are afforded access to methadone or buprenorphine maintenance treatment, the research-proven gold-standards for treatment of opiate addictions. This reluctance to refer is related to antiquated moral debates over methadone as “just another addiction.” Judges should not be permitted to consider opiate agonist maintenance as a contraindication to progress.

Chronic Psychoses: Over 50% of Prop 36 clients use methamphetamine as their drug of choice, half have never been in any prior treatment. This drug is well-known to produce dose-related paranoia in most users. It is less well-known that chronic use frequently produces a permanent psychosis (paranoia and hallucinations) that often requires chronic medical management with antipsychotic medications. Access to such medications is especially important in the face of the violence that can be engendered by such psychotic states. Monies from the Mental Health Initiative (Prop 63) need to be applied for the benefit of this dual-diagnosis population.

Misusers of Social Service/Welfare Benefits: Many addicts who receive county, state, or federal benefits frequently spend the bulk of this income for illicit drugs. Increased implementation of third-party payee systems is essential to guaranteeing that welfare benefits flow first and preferentially for housing and food. This will reduce pressure on both the police force and hospital emergency services.

Budget Matters:



CSAM RECOMMENDATIONS:

1. **Medication Assisted Treatments**
 - ✓ Access to Methadone Maintenance
 - ✓ Medication for Dual Diagnosis disorders
 - ✓ Anti-relapse medications
2. **Psychosocial Treatments**
 - ✓ Patient Placement Criteria (ASAM PPC-2)
 - ✓ Increased access to residential care
3. **Assertive Case Management**
 - ✓ Drug Courts for criminal recidivists
 - ✓ Outreach teams for dropouts
 - ✓ Random, routine toxicology testing
 - ✓ Payee management of welfare benefits
4. **Outcomes Evaluation Research**
 - ✓ UCLA continuation support
 - ✓ Development of core data set
5. **Improved Funding Base**
 - ✓ Pre-Incarceration Focus
 - ✓ Increased funding support

1. Medication Assisted Treatments

Access to Methadone Maintenance:

Approximately 10% of Prop 36 arrestees use heroin, but only 10% of them are referred for OAT (opiate agonist treatment). In part this is an ideological barrier in some courts, in part ideological in some counties.

CSAM recommends:

- That counties develop access plans for methadone or buprenorphine. The latter can be prescribed from specially-licensed physician offices.
- Development of guidelines that discourage judges from prohibiting opiate agonist maintenance.

Medication for Dual Diagnosis Disorders:

UCLA data has shown that 53% of SACPA clients have been arrested for methamphetamine abuse and that methamphetamine has reached epidemic proportions in California. Stimulants in general are well-known to induce longstanding (often permanent) brain conditions of paranoia, hallucinations, and/or depression.

CSAM Recommends:

- Prompt and continuing access to psychiatric evaluation, and provisions for prescription and psychiatric management of antipsychotic or antidepressant medications.

- The state needs to base reimbursement policies on Current Procedural Terminology CPT service codes, not on domain of diagnosis.

Anti-relapse medications:

A growing array of medications is now available to reduce the frequency of relapse to alcohol or opiates. Most community substance abuse programs are social model and cannot provide access to medications of any kind.

This is an anomaly related to separate funding streams and reimbursement policies for the Department of Alcohol and Drug Programs (DADP) and the Department of Mental Health (DMH).

CSAM Recommends:

- DADP needs to request county plans for provision of medication services.

2. Psychosocial Treatments

Patient Placement Criteria:

One-size treatment does not fit all. Treatment intensity and number of adjunctive services (such as medications or domestic violence counseling) need to be individually determined.

CSAM Recommends:

- Utilization of ASAM Patient Placement Criteria (PPC-2)
- Increased access to residential care

3. Assertive Case Management

Drug Courts for criminal recidivists:

UCLA's April 2006 Report on fiscal outcomes has identified a subgroup (5 convictions in prior 30 months) of high utilizers who are highly recidivistic and highly expensive for both criminal justice and treatment services. This is similar to a problem well known in community mental health and in the parole systems—that a few individuals cost a vastly disproportionate amount of time and effort.

CSAM does *not* support the addition of “flash incarceration” as a means of ensuring “accountability” until Prop 36 episodes have been used up. CSAM conceptualizes Prop 36 treatment as the Emergency Room entrance and Drug Court as the Intensive Care Unit.

CSAM Recommends:

- High utilizers (1.6%) should be directly assigned to a higher level of supervised care in Drug Courts.

Outreach Teams for Dropouts:

30% of Prop 36 arrestees never make a treatment visit and a substantial proportion of those who do drop out early. Retention thru completion of a treatment course has emerged as a gold standard of comparison for efficacy.

CSAM Recommends:

- Each county needs to hire outreach workers to find no-show and drop-outs.
- DADP should insist that each county plan designate a pro-rated amount of funding to pay for these positions.
- Results of outreach should be tabulated.
- Failure of outreach should lead to a judicial termination of an episode of Prop 36 access.

Random, routine toxicology testing:

Drug testing was originally kept out of Prop 36 in order to prevent criminal justice sectors from declaring testing a form of treatment. However, both criminal justice systems and treatment systems need to do randomized testing as a matter of routine. Although we understand the initial motive, continuing to block this use of Prop 36 dollars is not productive.

CSAM Recommends:

- Funded testing is a necessary improvement, but will cost additional monies.
- New technologies are available for Q-tip testing of saliva, obviating the need for costly and undignified observed urine collections

Payee Management of Welfare Benefits:

Some individuals often divert their county, state or federal benefits checks to the purchase of illicit drugs. Such individuals tend to be high utilizers of community emergency services (ambulances, emergency rooms, hospitalizations, police pickups) and the local shelter systems.

CSAM Recommends:

- Development of third-party payee management systems for selected Prop 36 clients.

4. Outcomes Evaluation Research

UCLA Continuation Support:

DADP's data analysis has been weak from the beginning for a variety of reasons, including the fact that DADP's core data is limited. This has led to the necessity of UCLA's outcomes research group having to do focus groups and individual interviews to capture missing data elements. (A core dataset was originally recommended in CSAM's White Paper on recommendations for implementation).

The UCLA group has done a very fine job of analyzing very complex data.

CSAM Recommends:

- UCLA should be retained to build on excellent work thus far and continue to analyze outcomes in Prop 36.

Development of Core Data Set:

There is a national trend towards the development of standardized outcomes measures. UCLA needs to help design a core dataset that will be used by all 58 counties and all court jurisdictions. It should not be overly comprehensive and should not be a typical overly burdensome research database.

CSAM Recommends:

- It should provide data points for the key markers of recidivism, re-arrest rates, compliance, toxicology testing data, employment, and duration of treatment.
- DADP should use Prop 36 funds to hire a dedicated Prop 36 data analyst full-time.

5. Improved Funding Base

Pre-Incarceration Focus:

The May 2007 passage of AB 900 will infuse around \$50M into in-custody and parole-based treatments. Arguably, Prop 36 was designed to keep people out of jail, not to offer the best treatment for those who are leaving prison on parole. Funding should be bifurcated.

- Prop 36 funds should focus on pre-incarceration treatment.
- CDCR funds should focus on in-custody and parole treatments. The CDCR has newly deep pockets and a powerful lobby.

Increased Funding Support:

Prop 36 has been funded \$120M per year for the past five years. Another \$20M was available in 2006-07 through the Offender Treatment Program, but only for counties willing and able to match funds. Over six years, purchasing power has already decayed about 25% from inflation. Increased funding will improve outcomes.

- UCLA has estimated minimum needed funding at \$230M. A survey of county administrators put the actual need at \$270M.
- Funding anomalies need to be ironed out by DMH and DADP to make psychiatric assessments and prescription medication both *available* and *reimbursable*.
- Some Prop 63 (California Mental Health Services Act) funds need to be allocated as a supplement to Prop 36 funds to help care for the dual-diagnosis disorders in general and the persistently psychotic individuals in particular.